FAQ's – PREMIUMS AND ELIGIBILITY CHANGES

Income verification

1) ***Are photocopies of pay stubs acceptable?***
   Yes.

2) ***If a client does not provide pay stubs or other acceptable documentation, is the CSO required to attempt to verify income through other means (e.g., other systems, TALX, etc.)?***
   Yes, the worker would attempt to verify income before a "request for information" letter is sent to the client.

3) ***If a client does not receive pay stubs, is paid "under the table" and the employer refuses to verify income, what can the worker accept as verification?***
   While income verification is a requirement, this would be an exception. If the client has a SSN, the worker can use one of the automated systems or TALX. When special circumstances exist and client cannot get third party verification of the income amount, the client will be allowed to write a statement declaring the amount of income. If possible, the client should also get a collateral statement from a co-worker or another person with personal knowledge of the amount of the client's income and when the income is received.

4) ***How current are these automated verification systems?***
   The TALX system is very current. The ACES cross match with Employment Security is one to two quarters behind. The TALX system will not be fully operational until this fall or later**.**

5) ***If income verification is done through an automated system, will the client be notified of the results (e.g., what system was used, what time period was verified and the income amount)?***
   If there is a discrepancy between what the client states their income is and what the income cross matches show, the worker is to pend the case, and contact the client or send a "request for information" letter to clear up the discrepancy.

6) ***Once the income verification is done, what income methodology will workers use?***
   There are two income calculation methodologies:
   - Anticipated Monthly; and
   - Combined Average

   For most medical programs, workers will use the Combined Average Methodology. For more information, refer to the **July 2003 memo**.

7) ***What provides DSHS authority to remove continuous eligibility?***
   The comments section of Program 080, 2003-05 Omnibus Operating Budget, states the following**:**

Increased Eligibility Verification - As provided in the 2003 supplemental budget, the Department will increase efforts to assure that recipients of publicly funded medical assistance meet applicable income, residency, and other eligibility requirements. Specific changes include:

(1) Verifying applicants' declared income through employer contacts and electronic records checks;

(2) Re-verifying eligibility at least every six months, rather than annually as was previously done for children's and family medical coverage; and

(3) Discontinuing coverage if subsequent income changes make the child ineligible for coverage, rather than continuing the coverage for a full year despite such changes as was previously done.

These changes are expected to result in approximately 4,800 (1.9 percent) fewer persons qualifying for publicly funded medical assistance in FY 2004, and in approximately 19,000 (3.4 percent) fewer receiving such assistance in FY 2005. The FY 2004 savings are significantly lower because electronic eligibility system changes needed to implement the six-month eligibility changes cannot be implemented until January 2004. In addition, these changes are expected to result in $4.3 million ($2.1 million state funds) of avoided expenditures in the Mental Health program. Additionally, 96 FTEs are funded in the Economic Services Administration to conduct the necessary eligibility reviews, at a cost of $10.6 million ($5.8 million state funds). The net state savings from this change are expected to total approximately $23 million for the biennium. (General Fund-State, Health Services Account-State, General Fund-Federal)

Reporting Changes

1) ***What income change rules apply to self-employed people?***
In most cases, the client may either:
   a) Average their self-employment income; or
   b) Use actual monthly income.

If they are paid only once or twice a year for income earned throughout the year, their income is averaged over the period of time it is to cover. If their job were seasonal, such as picking fruit, the worker would anticipate their income for June - September and tell the client to report if in October self-employment hours have reduced or terminated.

2) ***For people who have income fluctuations because of the nature of their work (e.g., seasonal workers), what should they report and when?***

It is mandatory to report within 20 days when:

- Employment stops or starts;
- The client goes from full to part time; or part time to full time; or
- Their hourly rate of pay or salary changes.

A client may report when the number of hours they work goes up or down, but it is not mandatory to report. (Reporting requirements are in WAC 388-418-0005.) If the client's wages are averaged at the time of application or review, the worker has taken into account the monthly fluctuation of the client's income.

3) ***What will happen if a family fails to report income fluctuations or changes? Will the department establish overpayments and collections?***

It is not the department's intent to focus on the establishment of overpayments. A client who disregards required reporting is likely to have their application or review scrutinized more closely. In such cases, the worker can also set a shorter certification period.

Premiums:

1) ***How will changes in premium levels be coordinated between FSA and ESA?***

The computers at ESA and FSA interface. ACES will send the premium information to FSA monthly on or after ACES cut-off.

2) ***What is the status of the waiver that will allow DSHS to charge premiums for optional children?***

MAA submitted the waiver to the Centers for Medicare and Medicaid Services on July 15, 2003.

3) ***Are any of the optional children exempt from premiums?***

Yes. Children with family income under 100% FPL, pregnant children, and children identified as an Alaska native or American Indian are exempt from the premium requirement.

4) ***If a client is sponsored, will the sponsor receive notices and review forms or copies of those things?***

This issue is under discussion. We are exploring methodologies under which a sponsor could receive a copy of the bill, but have not yet resolved that issue

5) ***How will the premium level be determined if there are two kids in the MAU - one child is age 6 months and the other is age 2?***

We are designing ACES support to calculate eligibility for each individual child in the household. ACES will assess eligibility, exempt some children and, for optional children, determine the premium band. ACES will then calculate the

premium maximum for the family and FSA will bill a rolled up premium amount for the children.

In your example, let's assume the family income is just slightly under 200% FPL. Both children are optional and would be in Band B at $20 per month each. FSA will bill the family $40 per month.

If we assume income at slightly under the 150% FPL level, the premium is Band A at $15.00 per month and the six-month old child is exempt. FSA would bill $15.00 per month.

If we assume income under the 100% FPL, both children are exempt.

The age and countable income for the individual child determines the amount of the premium.

6) ***When determining the family maximum for premiums, why did DSHS decide to bill a family for the three highest premiums instead of the three lowest premiums?***
Substantial savings are expected with the implementation of premiums. To reduce this hardship on families, we created a maximum of the three highest premiums. The following is an example of a four-child family:

	Income	**Premium**
Child 1	101%FPL	$15
Child 2	151%FPL	$20
Child 3	201%FPL	$25
Child 4	101%FPL	$15

Total premium amount at three highest equals $60.
Total premium amount at three lowest equals $50.

The children in most families will have the same premium amount. Regardless of family size, the family will be billed for only three children.

7) ***What if the family cannot afford to pay their premium this month? What constitutes good-cause for non-payment?***
At the current time, the department has not established hardship criteria or good-cause reasons for non-payment of premiums and no hardship criteria were included in the proposed waiver.

8) ***What if the family decides it can afford to pay their premiums for only one of their two children?***
The family will have to communicate that decision to their worker at the CSO and proactively request that the child be removed from medical coverage. The family cannot simply pay for one-half of the premium bill. They will soon owe an amount for three months and all optional children in the household are subject to termination and a three-month period of ineligibility.

9) ***How will CSO workers know about premiums and status?***
CSO workers will have access through ACES to the premium calculations and client notification. MAA and FSA are working together to provide CSO staff access to the invoices or premium billing statements.

10) ***How will families be notified of the premium requirement?***
Families will be sent general notices about premiums, we will provide information to community partners, community trainings, and training of CSO staff. Prior to billing, families will receive notice of the premiums amount for each optional child in the household.

11) ***How will families know they are getting behind in payment of premiums?***
Each bill will show the total amount due. A bill with a two-month or three-month total of premiums due will have a warning notice on the bill.

12) ***When premiums are charged, can families still receive retro coverage?***
Yes, families can request retroactive coverage for their children. Retro coverage is available when the child met eligibility criteria during that three-month period of time and had received covered medical services. The department will not approve retro coverage for any month that is included in a period of ineligibility.

13) ***When children are in the three-month period of ineligibility, what will show that on the medical ID card?***
A child in a period of ineligibility is not eligible. The child will not have a medical ID card issued for that period of time.

Other questions:

1. ***How can outreach workers get into ACES?***
Outreach workers cannot have access to ACES. The most important reason is client confidentiality.

2. ***Can DSHS provide an update on eligibility changes at the Spokane WCOMO meeting?***
Yes.

3. ***Will all CSO's administer these changes in a consistent manner?***
The policy is consistent statewide. Often there are procedural differences from one CSO to another.